Los Angeles County – Department of Health Services

# CLAIM FOR NATIONAL SPECIALTY AND BOARD CERTIFICATION REIMBURSEMENT

**INCOMPLETE OR ILLEGIBLE APPLICATION FORMS WILL NOT BE PROCESSED**

Please submit proof of payment along with proof of successful completion of the course.

*

| SETION I. EMPLOYEE INFORMATION | | | | | |
|---|---|---|---|---|---|
| Last Name | | First Name | | | |
| Employee No. | | Item No. | | Dept No. | |
| Mailing Address | | | | | |
| Work Location/Area | | Work Phone No. | ( ) | | |
| Work Address | | | | | |
| Email Address (County) | ( ) | Cell Phone No. | ( ) | | |

| SECTION II. COURSE INFORMATION | | | | | |
|---|---|---|---|---|---|
| Course Title | | Course No. | | Units | |
| Course Begins (MM\DD\YY) | | Course Completed (MM\DD\YY) | | | |
| We would appreciate your evaluation of the course you attended from the standpoint of its value to your department in meeting its goals and objectives. This information is for the use of your department and Civil Service in future tuition reimbursement planning. Your evaluation in no way affects this Claim for Reimbursement. | | | | | |
| 1. What did you learn in this course? | | | | | |
| 2. As a result of taking this course, how will you apply what you learned to your job? | | | | | |

| | | | | | |
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| Course Begins (MM\DD\YY) | | Course Completed (MM\DD\YY) | | | |
| We would appreciate your evaluation of the course you attended from the standpoint of its value to your department in meeting its goals and objectives. This information is for the use of your department and Civil Service in future tuition reimbursement planning. Your evaluation in no way affects this Claim for Reimbursement. | | | | | |
| 1. What did you learn in this course? | | | | | |
| 2. As a result of taking this course, how will you apply what you learned to your job? | | | | | |

| | |
|---|---|
| Total Tuition Fee | $ |

| I request reimbursement for the national specialty and board certification fees paid as listed above. Proof of payment and proof of successful completion are attached. I understand that if I terminate my permanent employment with the County within one year after the completion of this course, I shall be required to return the full amount of this reimbursement to the County. | | | |
|---|---|---|---|
| Date | | Employee Signature | |

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| SECTION III. TO BE COMPLETED BY FACILITY NURSE RECRUITMENT OFFICE OR NURSING ADMINISTRATION | | | |
|---|---|---|---|
| FACILITY NURSE RECRUITMENT OFFICE OR NURSING ADMINISTRATION OFFICE DESIGNEE USE ONLY | | | |
| Reviewed and approved by Facility Nurse Recruitment Office or Nursing Administration Office Designee: □ YES □ NO | | | |
| | | | |
| Date | | Signature | |
| Payroll Title | | Print Name | |

| | |
|---|---|
| AMOUNT TO BE REIMBURSED | $ |